Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GROUP
7401 S MAIN
HOUSTON TX 77030

Respondent Name
Hartford Fire Insurance Co

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-0463-01

MFDR Date Received
October 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim has been sent multiple times 1st mailed on 2/8 to dd address with old clm# then faxed on 6/7 showing new clm# as of 10/10 still not showing claim on file."

Amount in Dispute: $176.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Hartford is in receipt of Fondren Orthopedic's request for medical dispute resolution and has placed the bills for the disputed services in line for payment."

Response Submitted by: BURNS ANDERSON JURY & BRENNER LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2012	Professional Services	$176.66	$176.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.240 sets outs time limits for carriers to take final action on complete medical bills.
3. 28 Texas Administrative Code §134.203, titled Medical Fee Guideline for Professional Services, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §129.5 sets out payment limits on billable reports.
5. No explanation of benefits was available for the services in dispute.

Issues

1. Is the carrier required to process claim within time limit?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.240 states, in pertinent part, "the carrier shall take final action after conducting bill review on a complete bill, or determine to audit the medical bill… not later than the 45th day after the date the insurance carrier received a complete medical bill." Review of submitted documented finds the carrier received the bill but has not processed the claim. Therefore, these services will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2012, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-facility Price or;

Code	MAR Calculation	Units	Allowable
99213	(54.86 / 34.0376) x 70.64	1	$113.85
99080 (73)	Per rule 129.50 reimbursement shall be $15.00	1	$15.00
73000	(54.86 / 34.0376) x 29.66	1	$47.80
		Total	$176.65

3. The total allowable for the disputed services is $176.65. This amount previously paid by the insurance carrier of $0.00. The remaining balance due the provider is $176.65. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $176.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $176.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.